Out with "the old," elderly, and aged

PERSONAL VIEW **Marianne Falconer, Desmond O'Neill**

In his analysis of the challenge of simultaneously assisting and engaging in a respectful way with groups of differing status in society, the sociologist Richard Sennett reflected on why respect—which, unlike food, costs nothing—is in such short supply. One answer lies in the language we use. Listening to the wishes of clients and patients with disability or of a different ethnicity has led to a more sensitive use of language in encounters with people from these groups.

Older people, who not only are key clients of health services but also experience ageism as a widespread and potent barrier to adequate health care, have clearly signalled their wishes to be addressed in respectful terms. In a Europe-wide survey they have articulated a preference for "older" or "senior" as the defining adjectives for their demographic grouping. They also said which terms they deemed unacceptable: "elderly," "aged," and "old," with a particularly forceful rejection of elderly. This is echoed by the Human Rights Commission of the United Nations, which has outlined clearly in the International Covenant on Economic, Social and Cultural Rights why the descriptor "older" should be used.

Yet the terms used to describe older people vary markedly in the biomedical literature and official policy documents. Perhaps the most common undesirable usage is that of "elderly," a term that in any other context is invariably pejorative: who wants to buy an elderly car or travel in an elderly aeroplane?

Who wants to buy an elderly car or travel in an elderly aeroplane?

Two main phenomena of ageing in later life may be obscured by the use of terminology that is simultaneously pejorative and reductionist. The first is that the many positive aspects of ageing in later life, such as wisdom, experience, enhanced creativity, strategic skills, and maturity, are often overlooked in an ageist society, and such qualities are a critical component of successful ageing. Are the late great works of Verdi, Matisse, and Bellow the works of "elderly" or "older" artists? The second is the greater variability between individuals: populations of older people are more complex and heterogeneous than younger cohorts, and the corresponding complexity of their healthcare needs are ill served by negative collective phrases such as "elderly" rather than the more dispassionate "older."

SIPA/REX

Are the late great works of Verdi the works of an "elderly" or "older" artist?

In scientific terms the greatest risk is that what commentators really mean by "elderly" is a well meaning but misguided attempt to envelop the major clinical issue of frailty into a term that applies to all older people. Frailty is an important factor in functional decline, morbidity, and mortality for some older people, and much progress has been made in defining the phenotype, risk factors, manifestations, and outcomes of frailty as a clinical syndrome. However, most older people are not frail, and the proportion of older people who are disabled is dropping. Therefore, further understanding of the syndrome of frailty is not well served by a population descriptor that implies that all older people are affected by frailty. A better approach would be to promote clinical skills that selectively identify frail older people in preventive, community, and hospital care, as well as skills and pathways to improve care of this vulnerable group.

Editors of medical journals could usefully discuss whether or not they would promote the same sensitivity and precision in portraying older people as they would do with people from ethnic minorities and those with disability and to begin to describe older people in a way that respects their complexity, contribution, and civic engagement. Indeed, above and beyond avoiding the word "elderly," journal editors could look into the future and reflect on whether they might anticipate future thinking on what it means to be an older person. Perhaps the sharpest stimulus is the realisation that most of us will live to be older people and that we all have a stake in ensuring that the matrix within which our care system is embedded is sensitive to the increasing heterogeneity of our needs. Moving from the sense of a group that is separated from us by time and by pejorative descriptors towards an identification with our own future might be promoted by an imaginative turn of phrase: could "us as we age" be a useful starting position?

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A longer version of this article with references is available on bmj.com

Just the psychiatrist for a troubled young man, p 319

Exploration or exploitation?

Does conducting clinical trials in the world's poorest countries lead to unethical practice, asks **Ike Iheanacho**

What a start: having a glowing foreword by John Le Carré must be a coup for any book, particularly one focusing on the attitudes and behaviour of the drug industry. Views from this gifted writer begin Sonia Shah's book and are lavishly quoted on its jacket. Who would not want such high profile endorsement of their work? And yet there are risks for the praised author. The juxtaposition of her words with those of an undoubted authority invites unfair, and presumably unwanted, comparisons with his mastery of the subject and clarity of expression. For the most part, Shah's book is up to such critical exposure.

Shah's main theme is the often suspect nature of current testing of drugs in developing countries. She develops her argument through retrospective assessment and reportage of the conduct of clinical research. Unsurprisingly, the drug industry comes in for heavy (sometimes one sided) criticism throughout. But, as Shah shows, it is only with the tacit agreement of Western society at large and, crucially, the overt support and encouragement of medicines regulators that multinational drug companies can follow their commercial instincts.

One demonstration of this is the common overuse of placebo controlled trials to assess new drugs, despite the availability of alternative, active comparators. It is easy to see why companies prefer an investigative approach that avoids the need to prove equivalence to (let alone advantages over) longer established treatments. Less acceptable is how regulators often conspire in this process by making placebo controlled studies so central in their assessments of the efficacy of drugs. It suits companies and regulators alike to have smaller, quicker, and cheaper studies that show that drugs have some therapeutic effect. Whether such expediency is in the public interest is another matter.

The uncalled-for placebo controlled trial is just one, quite modern, way in which humans have been cheated or mistreated under the guise of "research." In a broad historical sweep Shah describes key examples of where the misinformed, the gullible, the helpless, and the desperate have been corralled, sometimes unwillingly, into tests that have had no chance of doing them any good. The long, ignoble tradition of such inquiry is limited neither to drug research nor poor countries. While nothing matches the barbarically bizarre experiments of the Nazis, there have been too many other situations where frank cruelty has been allowed to pass for good science by researchers who should have known better.

Of course, some things have changed, at least in industrialised countries. Bioethical thought has emphasised the requirement for informed consent from participants in any clinical research. This and the development of regulatory frameworks for drugs offer important protection against abusive research.

But those who believe that ethical considerations automatically safeguard against questionable research might be shaken from their complacency by Shah's evidence and counter-views. For a start, there is nothing absolute about research ethics—no universally agreed set of rules and standards that ensures that a study considered morally unacceptable in some parts of the world cannot take place elsewhere. On the contrary: the fact that people in developing countries might need, but do not have, access to a proven treatment can be used to "justify" their recruitment into studies where the control group receives an inferior treatment or placebo—research that would not have made it past the proposal stages in a wealthier country. This is done on the dubious grounds that these people are not being deprived of a treatment they would normally have received.

Such uneven application of ethical principles is having worrying consequences for the developing world. The various strictures on whether and how trials can be carried out in Western countries are fuelling the proliferation of clinical pharmaceutical research in poorer areas where such limitations are often absent, bypassed, or ignored and participants are both abundant and compliant. This modern day colonisation reflects drug companies' difficulties in recruiting trial patients in their home countries and their wish to contain research costs. Given these primary motivations, it is dangerous to assume that the relocation of research will be to the long term advantage of the new recruits (or their fellow citizens), not least because participation does not necessarily guarantee future access to the treatments being studied.

The Body Hunters does not get everything right. In discussing drug companies' frenetic search for new and profitable treatments, Shah cites the development of statins. These are witheringly dismissed as a demonstration of the dissonance between drug industry fixations and public health needs; and there is barely a mention of the drugs' clinical benefits in people at high risk of atherosclerotic complications. Such therapeutic myopia does the book little credit. Overall though, Shah has produced a well researched and passionately argued analysis of an important and rapidly developing field.

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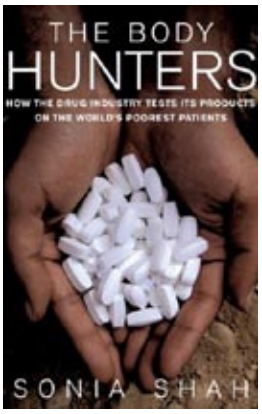
REVIEW OF THE WEEK



The Body Hunters: How the Drug Industry Tests its Products on the World's Poorest Patients

Sonia Shah

The New Press, £12.99, pp 256
ISBN: 978 1 56584 912 9

Rating: ★★★☆

While nothing matches the barbarically bizarre experiments of the Nazis, there have been too many other situations where frank cruelty has been allowed to pass for good science

The hippy, hippy shake down

FROM THE FRONTLINE
Des Spence

"We can't wear these," said my brother, as he picked up the flared and heavily embroidered jeans—pink and yellow flowers spelled the word "LOVE" so large I swear it was visible from space. However, we had no choice but to wear our girl cousin's hand-me-downs, because clothes were expensive in the 1970s. The Chinese then were busy tilling the soil rather than fuelling a pandemic of consumerism. "Alternative" lifestyles were the fashion, and we served our self sufficient sentence in Scotland. Our goat Nettie (kept for milk, not sacrifice) lived in a Morris Princess in the back garden; we kept chickens and grew our own vegetables. But the alternative lifestyle turned out to be smelly, cold, wet, and, frankly, depressing. I am hoping to raise a class action against the television series *The Good Life* for mis-selling and causing psychological distress.

But what of alternative medicine? The likes of reflexology, phrenology, herbs, crystals, whale music, and Chinese medicines (except those laced with steroids) are all just expensive placebos for the tree hugging, paranoid conspiracy theorists who see doctors as right wing conservatives in the pay of big multinationals.

In contrast, our conventional medicine is "scientific." Grey haired druids with laser pointers and PowerPoint animations use incomprehensible statistical incantations and—"kapow!"—halve a relative risk to deafening applause. But don't be fooled: medical research is just another dark art. A heady brew of ghost writing, suppression, manipulation, subgroup analysis, selective study groups, and concealed absolute risk transforms minor risk factors into medical monsters. Modern medicine now micromanages all our lives and has great capacity to do harm. So, it is little wonder that many people instead head for a groovy saltwater immersion tank.

Our derision merely feeds the conspiracy theories. If these placebos make patients "feel" better, and as long as they are safe and inexpensive, then where's the harm? In time, most people will revert to boring but functional conventional drugs.

Goats, Morris Princesses, and chickens make me smile, though I am still wary of women's clothes.

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So many, so wrong

PAST CARING
Wendy Moore

COLIN CRISFORD

Somewhere in the basement beneath the Hall of Fame there is a dusty broom cupboard reserved for those who have championed history's greatest medical errors. Here are remembered those often well meaning and frequently hard working souls who have committed their lives to pushing medical progress in completely the wrong direction. Some might suggest that damaging public faith in a safe and highly effective vaccine against childhood diseases would guarantee a future place. But space is at a premium, since the past can already furnish numerous examples of pioneers who have singlehandedly set back the course of medicine.

Perhaps the most reckless was Max von Pettenkofer, who in 1892 drank a broth containing excrement from a patient who had died from cholera in a foolhardy bid to prove the disease was not carried in water. Declaring that if he died, "I should die in the cause of science, like a soldier on the field of honour," he survived—though not with honour. Others who have contributed hugely to medicine have occasionally erred in the wrong direction too. Florence Nightingale and Edwin Chadwick can be forgiven their support for the miasma theory on account of their sterling contributions to public health.

But by far the largest space in the cupboard is reserved for Claudius Galen, physician to the Roman emperors, whose advocacy of bloodletting held sway for an incredible 1700 years. Born in Pergamon in AD 129, Galen studied medicine in Alexandria before attaining imperial advancement in Rome. A brilliant self publicist, who staged public demonstrations in which he silenced a squealing pig by severing its spinal cord, Galen popularised the Hippocratic theory that all illness resulted from an imbalance in the four bodily humours. Letting blood at specific points was his favourite remedy for restoring balance; he once denounced a quack for letting blood from the "wrong arm."

His daily dissections of apes, pigs, and sheep led him to numerous mistaken conclusions on the human body, which remained unchallenged until the 16th century.

Yet Galen silenced his critics as effectively as he stifled the pigs by the sheer volume of his writings, publishing more than 130 treatises. Many of Galen's teachings were eminently sensible. Yet his undoubted contributions have been far outweighed by the endurance of his belief in bloodletting, which enjoyed huge public acclaim.

If not offered bloodletting, many patients demanded it until well into the 19th century. Samuel Johnson recommended being bled till the point of fainting, surgeon Benjamin Rush is thought to have killed George Washington with his enthusiastic phlebotomy, and Mrs Beeton even published instructions for self bleeding in an emergency. Poor Galen would have been aghast that medics ignored his overriding doctrine—to base diagnosis and treatment on reason supplemented by observation and experience—but his place in the broom cupboard is assured.

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Is it so good to talk?

BETWEEN THE LINES
Theodore Dalrymple

Job asks the pertinent question: "How long will ye vex my soul, and break me in pieces with words?"

In a recent article commemorating the 40th anniversary of a national disaster, I noticed that one of the survivors complained that he had not received counselling when it happened, which he took to be a sign of official callousness and neglect. I mean the man no disrespect when I ask: Exactly when did the superstition arise that for every human sorrow there is equal and opposite counselling?

When I qualified, which does not seem to me to be so long ago, no one had ever heard of counselling. Does this mean that we were all cold and unfeeling, or that we could still count on the fortitude of our patients? Fortitude is an unfashionable virtue nowadays—indeed it is hardly considered a virtue at all, being more akin to resistance in psychoanalysis than to the laudable exercise of self control. Sometimes I wonder whether we admire emotional openness because we want so badly to speak of ourselves.

Not that counselling is really anything new; it appears in the book of Job. Job, you will remember, came from the land of Uz, and was pretty well off, with sheep, camels, oxen, and she-asses galore. He was also a good man, at least in his own estimation, for even sexual temptation was beyond him:

"If mine heart have been deceived by woman, or if I have laid wait at my neighbour's door, Then let my wife grind unto another, and let others bow down upon her."

Job's uprightness notwithstanding, the Lord saw fit to visit upon him, with Satan as an intermediary, an unpleasant illness: "… and [Satan] smote Job with sore boils from the sole of his foot unto his crown. This was the final straw, Job having previously lost his possessions and all his relatives thanks to Satan's machinations, and he lamented much."

It was then that his three friends, Eliphaz the Temanite, Bildad the Shuhite, and Zophar the Naamathite, offered him counselling. Eliphaz remarked that in his time of prosperity Job himself had been a counsellor: "Behold, thou hast instructed many, and thou hast strengthened the weak hands. Thy words have upholden him that was falling, and thou hast strengthened the feeble knees. But now it is come unto thee, and thou faintest; it toucheth thee, and thou art troubled."

I must confess that, whenever I have tried (usually without success) to strengthen the feeble knees—my patients—I have wondered whether, if it touched me, I would be troubled. And that thought alone had been enough to trouble me.

On the whole, Job didn't find counselling helpful. His bitterness went too deep, the world was too much with—and against—him. "Upon my right hand rise the youth; they push away my feet, and they rise up against me the ways of their destruction. They mar my path, they set forward my calamity, they have no helper."

Just like the youth of today, in fact. But it is Job's estimation of the worth of counselling that most strikes me: "How has thou helped him that is without power? How savest Thou the arm that hath no strength? How hast thou counselled him that hath no wisdom?"

Job asks the pertinent question: "How long will ye vex my soul, and break me in pieces with words?"

I think the explanation is to be found in one of La Rochefoucauld's terrifying little maxims: "There is in the misfortune of our friends something not entirely unpleasing."

Theodore Dalrymple is a writer and retired doctor

MEDICAL CLASSICS

Ordinary People

Film released 1980

Robert Redford's directorial debut introduces us to a family that has lost a son, Buck, leaving both parents and the younger brother, Conrad, cast adrift. Unusually for a Hollywood production, the film focuses on a young person with psychiatric problems and also on the positive input of a psychiatrist. The underlying premise seems to be that a tragedy unleashes the demons lying within a typical affluent middle class family.

Most of the story, based on the book by Judith Guest, is told from the perspective of Conrad, played by Timothy Hutton, who had always languished in the background while Buck had been the golden boy. The film invites us to watch a teenager struggle in the midst of his family falling apart.

Conrad's parents, skilfully acted by Mary Tyler Moore and Donald Sutherland, are so caught up in their own grief that they are unable to connect with and help Conrad. In particular, his mother appears to blame Conrad for Buck's death, which resulted from a boating accident. Her glacial presentation leaves us in no doubt that, for her, the wrong son died. The father on the other hand is struggling not only with Buck's death but also with a disintegrating marriage, which leaves little energy to deal with his surviving son.

Conrad has distressing flashbacks and nightmares and feels guilty that he survived instead of Buck. At the start of the film, he has returned from a psychiatric unit having cut his wrists, but is still not coping and is referred to a new psychiatrist, Dr Tyrone C Berger (played by Judd Hirsch). He attends reluctantly but slowly begins to trust this stranger. Dr Berger has an abrasive style but a clear commitment to troubled young people.

PARAMOUNT/KOBAL

Just the psychiatrist for the job: Dr Berger (right) with Conrad

This was my first contact with an adolescent psychiatrist, albeit fictional, and I was impressed by how he engaged with this struggling teenager, appearing to understand the conflicting powerful emotions Conrad was feeling, and, unlike his family, refusing to deny his distress or patronise him.

The climax of the film occurs when Conrad, in crisis, phones Dr Berger and his whole sense of guilt and blame for Buck's death pours out. Unlike Conrad's family, Dr Berger is able to tolerate this catharsis, respond to him, and absolve him of blame. This begins to relieve Conrad of his terrible burden. Although his mother is as distant as ever, his father is finally able to respond to, and love, the son who has been left.

The part of Dr Berger is idealised, but his ability to face Conrad's distress and help render it into something that can be managed is moving and compelling. Dr Berger is just the psychiatrist for a troubled young man: intelligent, full of compassion, and humanity, but also challenging and prepared to use humour.

Elaine Lockhart, consultant psychiatrist for children and young people, Royal Hospital for Sick Children, Glasgow